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ABSTRACT

The move toward deinstitutionalization of chronic psychiatric patients has been hampered by inadequate community-based rehabilitation programs. To investigate whether psychosocial rehabilitation promotes higher levels of functioning in discharged psychiatric patients, assessments of social adjustment, recidivism, and a non-traditional measure of client demoralization were administered to 102 clients in a community psychosocial rehabilitation program. Results confirmed that a comprehensive support system, which assumes primary responsibility for patient mental health care, maintains or enhances the level of functioning in former psychiatric patients. Results showed very low recidivism rates, improved or maintained social adjustment, and a significant decrease in reported demoralization. (JAC)

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Comprehensive Psychosocial Rehabilitation: A Community Based Treatment Approach for Discharged Psychiatric Patients

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Abstract

Assessments of social adjustment, recidivism, and a non-traditional measure of client demoralization were administered in a psychosocial rehabilitation facility. Results confirm that a comprehensive support system, which assumes primary responsibility for patient mental health care, maintains or enhances level of functioning in discharged psychiatric patients.

Comprehensive Psychosocial Rehabilitation: A Community-Based Treatment Approach for Discharged Psychiatric Patients

Purpose. The move toward deinstitutionalization is generally accepted as a necessary step in the treatment of chronic psychiatric patients. However, as Omarin and Sharfstein report (1978), many community-based programs developed to serve the chronic population have been fragmented, uncoordinated and inadequate.

In comparing the psychosocial functioning of patients in psychiatric hospitals and those treated in the community, Bachrach (1982) found no significant improvements in community treated patients with the exception of those treated in programs with a psychosocial focus. Our study supports the literature in finding a positive effect of psychosocial treatment on this population but goes beyond previous work in that it investigates the effects of a more comprehensive program. It also introduced a new measure of demoralization to evaluate rehabilitation outcome. The study sought to investigate whether psychosocial rehabilitation promotes higher levels of functioning in discharged psychiatric patients; as evidenced by low rates of recidivism, high levels of social adjustment, and low levels of demoralization. Psychosocial rehabilitation is characterized by a set of programmatic activities, geared toward enhancing socialization and independent living skills, with the primary goal of improving functional level, rather than symptomotology. It is believed that by focusing on and raising functional level, psychotic symptoms will subside (Rutman, 1982). Our study was conducted at Brooklyn Psychosocial Rehabilitation

Institute, a comprehensive program in an urban setting. Services include a community residence, apartments, and a continuing treatment center which emphasizes socialization, vocational rehabilitation, independent living skills training and family support services.

Subjects. 102 clients involved in a psychosocial rehabilitation program were the subjects in this study. Most of them had some history of psychiatric hospitalization -- often multiple hospitalizations. Subjects ranged in age from 19 through 55 with a mean age of 33 and with 57% of the sample falling into the category of the emerging young adult chronic patient (19-34), i.e., the first generation of psychiatric patients treated primarily in the community. All subjects had been in the program at least six months and some for as long as four years, with a mean of two years.

Procedure. Our study utilized measures of social adjustment encompassing activity/vocational level and living situation; recidivism; and a non-traditional measure of client demoralization. Recidivism and social adjustment measures were taken from case records at three time points: 1) retrospective, i.e., looking back into the records to either six or twelve months, depending on the subject's length of stay in the program; 2) beginning of the study; 3) six months later. Recidivism was defined as the percentage of clients returning to inpatient treatment within a given time frame, and was also measured by number of days in hospital.

Social adjustment level was assessed by the Social Adjust-

ment Measure (SAM), an additive scale devised by us but based on Walker's (1972) Brockton Social Adjustment Scale (Chart 1). For each subject, their living situation and activity/vocational levels were rated from one to five. These two subscores were combined to form the subject's overall social adjustment score.

The third instrument, the demoralization scale of the Psychiatric Epidemiology Research Interview (PERI), consists of a 26-item self-report interview designed by Dohrenwend and his colleagues to measure non-specific psychological distress. In addition to demoralization scores, a subscale measuring self-esteem was used. Interviews were administered at the same time as the second and third assessment points for the measures of social adjustment and recidivism.

Results. The results in the area of recidivism showed very low rates, with a one-year rate of 28% and a rate of 34% after two years. These recidivism rates were lower than those reported for other community-based programs surveyed by Anthony, Cohen, and Vitalo (1978), whose review has been widely used as a standard of comparison. They found recidivism rates of 35-50% after one year, approximately 50-75% after two years, and approximately 55-65% after three years (Table 1). In our own review of the studies examined by Anthony, we found that often the nature of the treatment and demographic characteristics of the population were undefined. However, whenever community based treatment was clearly specified and the demographic characteristics similar to our own, a comparison revealed that our recidivism rates remained considerably lower.

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Two more recent studies of psychosocial treatment reported recidivism rates comparable to ours. In a study conducted by Beard, Malamud, and Rossman (1978) at Fountain House, a psychosocial rehabilitation program in New York, a portion of their sample received active and ongoing outreach services similar to our program. Their one and two year recidivism rates were 27% and 38% respectively, essentially the same as our rates of 28% and 34%. Another comparable psychosocial treatment program reporting research on recidivism was Thresholds, a privately operated rehabilitation center in Chicago. In their comprehensive treatment condition, which resembles our program in its individualized rehabilitation milieu, staff/client ratio, and overall attention to all aspects of client care, a recidivism rate of 14% after nine months was reported, but no rates were available for time periods comparable to our own study. We had hoped to find information regarding selection criteria for these two programs but have not yet obtained these data.

Data in the area of social adjustment were examined over time. Mean social adjustment scores were compared for the three SAM assessments. The results indicated significant improvement over the entire one to one-and-a-half years of the study (Table 2). However, during the final six months of the study, there was no significant change in social adjustment scores. Almost the entire sample (96%) either maintained or improved their level of social adjustment between assessments made over the duration of the study, with 45% improving

and 51% remaining the same. Only 4% of the sample worsened (x^2=37.189, df=4, p .01). The fact that there was a significant improvement in mean scores over time and that 96% of our sample maintained or improved their social adjustment level is a very positive result in view of the chronicity and level of impairment in our sample. Improvements in mean SAM scores apparent at one and one-and-a-half years and not during the six months between the last two assessments also suggests that rehabilitation with this chronic population is a long-term process.

Our analysis of the PERI data revealed a significant decrease in reported demoralization over a six month interval for both younger and especially older subjects, as measured by the mean PERI demoralization scores (Table 3). Contrary to our expectations, we found no significant association between PERI and SAM scores. This may be explained by differences in the focus of the two instruments. The PERI focuses on symptomotology while the SAM focuses more exclusively on functional performance.

The fact that there were improvements for both age groups across both measures may speak to the efficacy of treatment over time. One notable result was the significant decrease in PERI demoralization scores over a relatively short time period, compared with the longer time period needed to achieve significantly better SAM scores. One possible explanation for this was that demoralization scores for the second assessment may have been deflated by the subjects' familiarity with the interviewer over two assessments and their need to show

improvement. To rule out any such response bias, an analysis of variance of mean PERI scores obtained by each interviewer on both assessments was conducted and no significant differences were found. There is also the possibility that demoralization scores for the first assessment were inflated by situational factors. Agency logs for that period record numerous accounts of clients "acting out" and an inspection visit by the Office of Mental Health which may have increased stress on program clients and staff. However, the more likely explanation may be that over the short term, supportive psychosocial milieu can have a greater impact on the symptoms, attitudes, and feelings recorded by the PERI than it can have on vocational and housing issues which are also affected by education, training, and availability of community resources.

Implications and Conclusions. The overall results of our study confirm the efficacy of a comprehensive psychosocial rehabilitation program. This was particularly apparent with the more objective measurements of recidivism and social adjustment.

The significant improvement in demoralization according to self-report measures which paralleled SAM improvements also supports program effectiveness. In order to examine shifts in the more subjective measure of demoralization in greater detail, we will be conducting further statistical analyses comparing demoralization scores with the number of months spent in the program.

In closing we would like to suggest two possible directions for future research. A more comprehensive social adjustment

measure including other dimensions in addition to independent living and vocational status would probably prove to be a more sensitive measure than the one used in our study. The areas of interpersonal skills and family and social relationships might reflect more gradual functional improvement in a chronic psychiatric population whose greatest difficulty generally lies in meeting the demands of independent living.

In our attempts to compare our results with other research on similar populations, the question of differences in degree of chronicity, impairment, criteria for admission selection, and other confounding influences became quite apparent. Studies involving the random selection of subjects from various community treatment settings after the point of inpatient discharge would be very productive. To our knowledge there are very few in the literature at this time.

Chart 1: Social Adjustment Measure (SAM)

Living Situation		Activity/Vocational Level	
Independent Apartment	1	Competitive Employment	1
Adult Home	2	Vocational/Educational/Volunteer	2
Supportive Living Facility	3	Sheltered Employment	3
Supervised Living Facility	4	Work-like Activity	4
Hospital Inpatient	5	Day Program	5

Table 1: Recidivism Rates

Source	1 Year Rate	2 Year Rate
Brooklyn Psychosocial	28%	34%
Anthony's Review	35-50%	50-75%
Fountain House	27%	38%
Thresholds	14%*	--

*nine-month recidivism rate

Table 2: Social Adjustment Measure Over Time

SAM Assessment	N	$\bar{X}$	S
Retroactive	102	$\bar{X}_1$=3.78	S_1=1.42
Baseline	102	$\bar{X}_2$=4.78	S_2=1.92
Six Months After Baseline	102	$\bar{X}_3$=4.80	S_3=1.87

$\bar{X}_1 \times \bar{X}_2$: $p < .01$ $\quad \bar{X}_1 \times \bar{X}_3$: $p < .01$ $\quad \bar{X}_2 \times \bar{X}_3$: $p < .05$

Table 3: PERI Demoralization Score: First X Second Assessment

PERI X PERI		Assessment 1		Assessment 2			
(range:10-94)	N	X_1	S_1	X_2	S_2	t	p
Younger Adults (19-34 years)	58	50.12	16.83	45.95	17.99	2.55	.05
Older Adults (35-55 years)	44	54.07	15.10	46.91	17.35	4.13	.001

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